PRINTED: 09/12/2016 FORM APPROVED OMB NO. 0938-0391

AND PLAN C	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
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CLAIBO	PROVIDER OR SUPPLIEF RNE AND HUGHES I	ALTH CNTR		STREET ADDRESS, CITY, STATE, ZIP CO 200 STRAHL STREET FRANKLIN, TN 37064	DOE	/06/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE A DEFICIENCY)	28 O U O H2	(X5) COMPLETION DATE
F 241 SS=D	#39486, were com Claiborne and Hug were cited for #39 under 42 CFR PAI Term Care Facilitie #39486 were not were cited unrelate 483.15(a) DIGNIT INDIVIDUALITY The facility must p manner and in an enhances each re- full recognition of the This REQUIREME by: Based on medical and Interview, the dignity for 2 Reside reviewed. The findings Includ Medical record rev admitted to the faci including Bipolar I Organic Psychotic Dementia, Chronic Drug-Induced Psyc Hallucination, Vasc Disorder. Medical record rev Data Set dated 7/1	gations #39308, #39320, and appleted on 8/22/16 to 9/6/16, at appleted on 8/22/16 to emplaints #39320 and substantiated and deficiencies and to complaint. AND RESPECT OF aromote care for residents in a environment that maintains or sident's dignity and respect in a environment that maintains or sident's dignity and respect in a environment that maintains or sident's adjust and respect in a environment that maintains or sident's adjust and respect in all or her individuality. NT is not met as evidenced arecord review, observation facility failed to maintain the ent's (#6 and 7) of 9 residents and 9 resealed Resident #6 was allity on 4/10/15 with diagnoses Disorder, Senile and Pre-senile Condition, Arteriosclerotic Organic Psychotic Condition	F 24		an or nity and n of his or d linen sident #6 s sent to th clean om to ntinence made sed n a resident	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that following the date of survey whether or not a plan of correction is provided. For nursing homes, the findings stated above are disclosable 90 days days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

(X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			Т			OMB NO	0, 0938-0391
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		445157	B. WING				C
	PROVIDER OR SUPPLIER RNE AND HUGHES H	LTH CNTR		200	REET ADDRESS, CITY, STATE, ZIP CODE 10 STRAHL STREET RANKLIN, TN 37064	09	/06/2016
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	able to make self u others, was modera the Brief Interview if 15, no delirium, no basellne, no exhibit demonstrated, no be supervision with set and toileting, and wand bladder. Observation on 8/2: outside Resident #6 strong urine odor. Fupon entering the resident was on a high. Further observation reveale crotch area, secured upward toward Resident on the floor at the bed. Interview with Resident heater on stated in the resident's root the pajama bottoms the heater on stated had an accident so linterview with the Diat 9:35 AM, in Reside room smelled strong pajama bottoms were heater fan set on high on the side of the bed.	nderstood and understood ately cognitively impaired per or Mental Status of 12 out of change in mental status from ion of moods, no psychosis ehaviors exhibited, required t-up assistance for transfers as always continent of bowel 2/16 at 9:23 AM, in the hallway b's room revealed a very urther observation revealed com, the room was very warm, and the heater fan was set to valid to the heater and he was heater unit. Further d pajama bottoms, with a wet d to the heater unit blowing dent #6 seated on the side of servation revealed wet soiled against the wall at the foot of ent #6 on 8/22/16 at 9:25 AM, m, revealed when asked why were blowing in the air with "I have weak kidneys and	F2	241	 On 8/22/16 a walking ro audit of each resident's ri was completed by DON a Housekeeping Supervisor ensure each residents dig maintained as evidenced further odors being noted made with clean linen ansoiled linen disposed of properly. Corrections were made as needed. On 10/3/16 an all staff in service was started by the Administrator regarding dignity and respect of all residents in relation to 	oom nd the to nilty is by no l, beds d	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF I	PROVIDER OR SUPPLIER	445157	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	09/06/2016
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F 241	admission to the fa diagnosis including Deaf-Non-speaking	of the resident, ew for Resident #7 revealed cility on 11/15/95 with Blindness Both Eyes and	F 241	properly disposing of soile linen, odors on halls and resident rooms, approprial making residents bed with clean linen and residents eating meals in an environthat is free of odors and soil linens.	tely
	Data Set dated 7/2 absence of useful I no vision, required transfers and toileti incontinent of bowe Observation on 8/2 outside Resident # strong urine odor. Fentering Resident # #7 seated in a chair consumed breakfasin front of the overtray, was the reside sheets and a wet a incontinence pad w Interview with the E at 9:30 AM, in Resi	2/16 at 9:20 AM, in the hallway 7's room revealed a very Further observation upon 67's room, revealed Resident of with 75% (percent) at plate on the over-bed table Further observation revealed bed table with the breakfast and brown streaked of the avery strong odor of urine. Officector of Nursing on 8/22/16 dent #7's room confirmed the		4. Unit Managers, DON and Administrator will conduct environmental rounds daily ensure the environment is of odors, appropriate making residents hed with clean ling and proper disposal of soiled linens is maintained. Through these walking rounds all residents will be checked to ensure their dignity and respect is maintained. Concerns will be corrected immediately. Findings and a issues noted on the grievant log will be reported daily to daily QA meeting and reviewed monthly at the Plymeeting.	y to free ng of ten d gh 10/20/16
F 253 SS=D	urine odor was presolled and wet while meal was consume interview confirmed maintained. 483.15(h)(2) HOUS MAINTENANCE SI	sent, the bed sheets were early send the Resident #7's breakfast of in the room. Continued Resident #7's dignity was not SEKEEPING &	F 253	F253 The facility will provide houseke and maintenance services necess to maintain a sanitary, orderly arcomfortable interior.	sary

THE PART	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	X2) MULTIPLE CONSTRUCTION A. BUILDING		
		445157	B. WING		C	
	PROVIDER OR SUPPLIER RNE AND HUGHES H	LTH CNTR	2	TREET ADDRESS, CITY, STATE, ZIP COI 00 STRAHL STREET FRANKLIN, TN 37064	09/06/2016 DE	
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F 253	Sanitary, orderly, and the services provided by: This REQUIREME by: Based on observations and the services provided in the fact and th	nd comfortable interlor. NT is not met as evidenced tion and interview, the facility ices failed to maintain 1 6) in a sanitary manner of 32 the first floor. ed: ew revealed Resident #6 was lity on 4/10/15 with diagnoses Disorder, Senile and Pre-senile Condition, Arteriosclerotic Organic Psychotic Condition, hotic Disorder with ular Dementia, and Mental 2/16 at 9:23 AM, in the hallway resident #6 revealed a very further observation revealed the bed and the heater unit was on and black debris was irrector of Nursing on 8/22/16 dent #6's room, confirmed the gly of urine, the floor was notified housekeeping. RVICES BY QUALIFIED	F 253	1. On 8/22/16 Hous immediately cond through cleaning oresident #6 room, the strong urine oremoved the black debris on floor 2. On 8/22/16 a wal round audit of each resident's room worderly and completed by DON Housekeeping Supto ensure a sanitar orderly and comformaterior. Any other concerns were added and corrected immediately free of odor regarding the important and the Administrator regarding the important and keeps facility free of odor 4. Housekeeping Supton and Administrator conduct environment rounds daily to ensure a sabsence of odors are cleanliness of facility maintained. Concern be corrected immediately QA meeting reviewed monthly are resident and are reviewed monthly are resident and are resident are resident are resident as a resident as a resident are resident as a resid	ucted a of removed dor and c sticky king h as I and pervisor y, rtable lressed pediately. service rted by ortance of ry ping the s. ervisor will ental ure and ty is ns will diately. ported to g and	

STATEMENT	OF DEFICIENCIES	(X1) PROMDER/SUPPLIER/CLIA	/X2\ MIII TI	PLE CONSTRUCTION		0938-0391
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		G	(X3) DATE SURVEY COMPLETED	
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TAG	REGULATORY OR L	BC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
F 282	Continued From pa	ge 4	F 28	F282 The services provided or arrang	od by	
	care.		,	the facility will be provided by	ad by	
	N			qualified persons in accordance	with	
	This REQUIREMEN	NT is not met as evidenced		each resident's written plan of c		
	by:			to the second se	İ	
	Based on facility po	olicy review, medical record		Corrective Action 1. On 8/22/16 the order for	ļ	1
	data review, the fac	, interview, and pharmacy ility failed to follow the care		automatic flush was chang	ed to	1
	plan to administer the	ne tube feeding and flushes as		gravity flush per MD order	for !	
	ordered for 1 Resid	ent (#1) of 9 residents		resident #1.	1	
	reviewed.			The facility reviewed Diet Sheet form and there were		
	The findings include	ed:		negative outcomes from fa		
	David Section			to document on 8/16/16,		
	undated revealed "	licy, Tube Feeding-Hydration, Purpose: To provide proper		8/17/16, and 8/19/16 for resident #1. On 8/19/16,	1	
	hydration, via a feed	ding tubeStandard:		8/20/16, and 8/21/16 the	re !	
	Physician orders for	r tube feedings should include		were no negative outcome		
	the amount of water dayProcess: Reco	r to be given each		to one formulary and one being documented on for	lush	
	centimeters]The a	amount of water given at each		resident #1.		
	ordered flush, along	with the total amount given				i
	each day is docume	anted"			Í	
	Review of the under	ted facility policy entitled				
	"Intake and Output	Measurement of Fluids"			1	
	revealed "Purpose record of the reside	e: To provide an accurate			1	
	outputProcess: Fl	ulds fromtube feedings is				
	calculated and reco	rded by the licensed nurse"			1	
					1	
	admitted to the facili	ew revealed Resident #1 was lity pn 3/4/16, and readmitted			į	
	on 8/16/16 with diag	gnoses including Quadriplegia.				
	Bilateral Lower Extr	emity Deep Vein Thrombosis			1	
	Esophagus Chroni	strostomy, Disease of c Pain, Obesity, Anxiety,			1	
	Depression, Seizur	es, and Pressure Ulcer.			1	
	1055500	TOTAL CONTROL			į	1

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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CLAIBO	PROVIDER OR SUPPLIER RNE AND HUGHES H			200	REET ADDRESS, CITY, STATE, ZIP CODE 0 STRAHL STREET NANKLIN, TN 37064	1 08	0/06/2016
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F 282	Medical record revioriginal date of 3/12 "Resident is on to Flushes as ordered Medical record revidated 8/1/16 to 8/3- formula was Isosou, 70 cc for 22 hours, 52 cc per hour for 2 before and after ea Observation on 8/2 Resident #1 in bed formula, Isosource pole with 600 millilit pump was set at 70 hour. Further obserbag was hung on the Interview with Licen #4 on 8/22/16 at 12 station revealed who provided water flush water with medication have auto flus When asked what a "months at least., #4 at 12:58 PM at the when asked if any administered stated flush" When asked accounting for what flush stated " I hav Medical record reviewed.	ew of the care plan with the 2/16 and updated 6/14/16 the feeding" revealed "and I" ew of the Physician Orders 1/16 revealed the tube feeding tree 1.5 calorie concentrate at Water Flush Auto per pump at 2 hours, and water 30 ml ch medication pass. 2/16 at 12:18 PM revealed in his room, a tube feeding 1.5 Calorie, was in a bag on a ters (ml) in the bag and the 0 cc (cubic centimeters) per vation revealed no water flush he pole. ased Practyical Nurse (LPN) (1.22 PM at the 1 West nursing ten asked if the LPN had hes stated "I have provided ons" When asked if the LPN water flushes the LPN ian orders and stated " we she bags for awhile now" awhile meant the LPN stated " We she had he stated " we she had so the ten interview with LPN he 1 West nursing station water flushes were 1"No, we don't have auto and how he was calculating or the resident needed for the	F	282	 On 8/22/16 an audit was completed by the DON for tube feeding residents to ensure an order for gravity flush is in place. All tube feeding residents plan of c was audited and updated t reflect gravity flush. An audit on the diet flow sl form was conducted for all tube feeding residents by t unit managers, findings we presented at the QA meetir serviced on 8/22/16 regard following MD order and documentation of flushes of the Diet Flow Sheet in the T feeding section for nurses, a in-service was also started all licensed nurses regarding following the plan of care. An audit will be conducted all residents with tube feeding ensure that orders reflect water flushes via gravity. The Diet Flow Sheet form who he audited daily by the unit managers to ensure compliance findings will be reviewed by the PI/QA meet monthly 	y are to heet fie re ding n Tube An for g on ing to	10/20/16

STATEMENT OF	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			1	. 0938-0391
AND PLAN OF C	CORRECTION	IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
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888 888 888 888 888 888 888 888 888 88	717/16, and 8/19/1 nd 8/21/16 one for ocumented, nterview with LPN in the 1 West nursing /2016 Diet Flow Shailed to fill out the faterview with the D/24/16 at 8:25 AM, fanager (BOM) official of the fluids on the fater of the fluids of the f	documentation on 8/16/16, 6; and on 8/18/16, 8/20/16 mulary and one flush was 45, on 8/22/16 at 5:12 PM at station after reviewing the neet form confirmed the facility orm completely. irrector of Nursing (DON), on in the Business Office ce, confirmed the facility acility policy to document the every shift and failed to follow and care plan to provide tube to ordered. ARE/SERVICES FOR		282	Each resident will receive and the facility will provide the necessary and services to attain or maintain highest practicable physical, ment and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	care the al,	

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE 200 STRAHL STREET FRANKLIN, TN 37064	09/06/2016	
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F 309	The findings includ Review of facility prundated revealed "hydration, via a fee Physician orders for the amount of water dayProcess: Recontimeters]The ordered flush, alone each day is docum Review of facility process. To prove the including by the licensed nur Medical record reviadmitted on 3/4/16 with readmission to diagnoses including Extremity Deep Vei Gastrostomy, Diser Pain, Obesity, Anxi Pressure Ulcer. Medical record revidated 8/1/16 to 8/3 formula was Isoson 70 cc for 22 hours, 52 cc per hour for 2 before and after ear Observation on 8/2 Resident #1 in bed	ed: plicy, Tube Feeding-Hydration,Purpose: To provide proper ding tubeStandard: r tube feedings should include er to be given each ord the cc's [cubic amount of water given at each g with the total amount given ented" plicy, Intake and Output uids, undated revealed vide an accurate record of the ad outputProcess: Fluids s is calculated and recorded	F 309	Corrective Action 1.a On 8/22/16 the order for automatic flush was changed gravity flush per MD order for resident #1. The facility reviewed Diet Flesheet form and there were not negative outcomes from failed to document on 8/16/16, 8/17/16, and 8/19/16. On 8/18/16, 8/20/16, and 8/21/16 there were not negative outcome due to one formulary and one flush beind documented on. b. On 8/22/16 resident #2 received medication as ordered. 2.a. On 8/22/16 an audit was completed by the DON for a tube feeding residents to ensure an order for gravity flush is in place. There were other residents affected by a having the automatic flush in place. An audit of the diet flow she form was conducted for all residents by the unit manage to ensure completeness in regards to documentations. There were no other resider affected due to not having complete documentation of diet flow sheet form. finding will be presented at the QA meeting.	or ow out out no not no et ers its the	

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	2401 411				MR MC	1. 0938-0391
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						DEFICIENCY		i
F 200					b.	An audit was completed by	t blace	
F 309	Continued From pa		F:	309		Unit manager on 9/27/16	to	1
	pole with 600 millili	ters (ml) in the bag and the		- 1		ensure all physicians order	.U	1
	pump was set at 70	cc (cubic centimeters) per				were initiated timely for al	a) I	
	hour. Further obser	vation revealed no water flush		1		residents. Any negative	1	į l
	bag was hung on th	ne pole.				findings were corrected		
	WC446-C W. 494 1010	and Developed No.				immediately. Findings will	be	
	Interview with Licen	nsed Practical Nurse (LPN) #4				presented at QA/PI meeti	กฐ	
	on 8/22/16 at 12:22	PM at the 1 West nursing				C /	.0	
	station revealed wh	en asked if the LPN had		1	3.a.	All licensed nurses were in		
	provided water flus	hes stated "! have provided				serviced by the DON and U	nit	
	water with medicati	ons" When asked if the LPN				Managers on 8/22/16		
	had done any other	water flushes the LPN		i		regarding following MD		1
	checked the physic	ian orders and stated " we		- 1		order and documentation of	of	i l
	When asked what	sh bags for awhile now"		- 1		flushes. An in-services was		
	" months at loost	awhile meant the LPN stated ." Further interview with LPN		- 4		started on 10/5/16 by the	DON	1
	#4 at 12:58 DM at t	he 1 West nursing station		- 1		with all licensed nurses		!
	when asked if any	vater flushes were				regarding notifying MD to		1
	administered states	"No, we don't have auto				obtain a new order to mate	h	
	flush When aske	nd how he was calculating or				the facility protocol for tub	e .	
	accounting for what	t the resident needed for the		- 1		feeding water flush by grav	ity.	
	flush LPN #4 stated	i "i have a problem" LPN				The protocol is to use the gravity method instead of a	f	
	#4 confirmed they b	nad not administered 52 ml per				the auto flush method.	ising	
	hour flush as ordere	ed.		- 1	b.	An in-service was conducted	vł bu	1
					17.	unit manager and DON	u uy	
	Medical record revi	ew of the 8/2016 Diet Flow				regarding following MD		
	Sheet form, where	they document tube feeding		- 1		orders and initiating		1
	and flush ml every	shift, beginning from the		ı		medication timely per MD		
	readmission on 8/1	6/16 revealed no		- 1		order as evidence by Licen.	end	1
	documentation on 8	3/16/16, 8/17/16, and 8/19/16;				nurse obtaining a telephon		1
	and on 8/18/16, 8/2	0/16 and 8/21/16 one					_	
	formulary and one i	flush was documented.				ÿ.		
	Leton donor o dels 1 con							
	Interview with LPN	#5, on 8/22/16 at 5:12 PM at						
	the 1 west nursing	station, after reviewing the						1
	follow to till and the	heet form confirmed the facility		j				
	failed to fill out the f	form completely.						
	Interview with the P	Pirector of Nursing (DON) on						
	8/24/16 at 8:25 AM	in the Business Office						Ţ

STATEMEN	T OF DEFICIENCIES	(VI) DECUDED SERVICES				OWB NO	. 0938-0391
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	JIPLI	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER RNE AND HUGHES HI	LTH CNTR		20	STREET ADDRESS, CITY, STATE, ZIP CODE 200 STRAHL STREET FRANKLIN, TN 37064	1 09	/06/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRE	(X5) COMPLETION DATE
F 309	Manager (BOM) off to follow the facility of the fluids every sphysician order to pas ordered. Medical record reviadmitted to the facilincluding Chronic K Coronary Artery Dis Psychosis, and Der Observation on 8/22 Resident #2 in her rher chest and "8/22 Medical record revietelephone order dat patch [patch with Nicondition] 0.2 mg [mon in AM" Medical record revietelephone order dat patch [patch with Nicondition] 0.2 mg [mon in AM" Medical record revietelephone order dat patch [patch with Nicondition] 0.2 mg [mon in AM" Medical record revietelephone order data patch [patch with Nicondition] date of Transdermal 0.2 MC patch 24 HR" Furthwas initially adminis Review of the pharmacy received 7/30/16 and sent the pharmacy. Further repharmacy delivery tipatch was delivered on 8/2/16. Interview with LPN #	ice confirmed the facility failed policy to document the intake hift and failed to follow the provide tube feeding and flush are revealed Resident #2 was lity on 6/24/16 with diagnoses lidney Disease Stage 3, ease, Diabetes Mellitus, nentia. 2/16 at 9:05 AM revealed com with a patch visible on written on the patch. 2/16 at 9:05 AM revealed from with a patch visible on little on lit	F3	809	order, follow the authorizatelephone order, and obta physicians signature for the telephone order. 4.a. An audit will be conducted the Unit Managers on all residents with tube feeding and any new admission residents with tube feeding ensure that orders reflect water flushes via gravity. The Diet Flow Sheet form the beaudited weekly by the umanagers to ensure completeness findings will reviewed by the PI/QA memonthly. b. Chart checks for any new orders will conduct daily be charge nurse and double checked by the Unit Manage daily to ensure immediate initiation of MD orders is completed. This will be do for 6 weeks daily and then maintained weekly. Finding will be 5 reviewed by the P meeting.	in a ne l by g to will unit l be eting y pm l gers	10/20/16

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPL	-E CONSTRUCTION	NO. 0938-0391	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY
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NAME OF I	PROVIDER OR SUPPLIER	445157	B, WING			8 8	06/2016
CLAIBOI	RNE AND HUGHES H	ILTH CNTR		2	TREET ADDRESS, CITY, STATE, ZIP CODE 100 STRAHL STREET RANKLIN, TN 37064		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	185	(X5) COMPLETION DATE
F 309	the telephone order dated 7/30/16. Further interview revealed the nurse misdated the phone order and it was really written on 8/2/16. Further interview confirmed the facility failed to follow the physician order by failing to administer the medication upon receipt by the facility on 8/2/16. 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and			F 322 F322 Based on the comprehensive assessment of a resident. The fawill ensure that (1) A resident has been able to eat enough allowith assistance is not fed by na gastric tube unless the residen clinical condition demonstrate use of a naso gastric tube was unavoidable		rho or	
	gastrostomy tube retreatment and servi pneumonia, diarrhe metabolic abnorma ulcers and to restor skills. This REQUIREMENT by: Based on facility poreview, observation failed to label the tufailed to document	ecelves the appropriate lices to prevent aspiration sa, vomiting, dehydration, lities, and nasal-pharyngeal re, if possible, normal eating of the province of			(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormal and nasal-pharyngeal ulcers and restore, if possible normal eating skills.	ities,	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	DENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-0					
AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI	E SURVEY IPLETED		
		445157	D. WING	_			C		
	PROVIDER OR SUPPLIER RNE AND HUGHES H	LTH CNTR		91 20	TREET ADDRESS, CITY, STATE, ZIP CODE 10 STRAHL STREET RANKLIN, TN 37064	09/	06/2016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RE	(X5) COMPLETION DATE		
F 322	residents reviewed The findings includ Review of facility prediction of the amount of water dayProcess: Recontimeters]The ordered flush, along each day is docum Review of facility prediction of FI "Purpose: To provesident's intake an fromtube feeding by the licensed nur Medical record reviadmitted on 3/4/16 with diagnoses included the firm of the second reviadmitted on the second reviadmitted and Presided 8/1/16 to 8/3 Nurse (LPN) #4, at at 12:23 PM, reveated the second reviadmitted on the second reviaded 8/1/16 to 8/3 Nurse (LPN) #4, at at 12:23 PM, reveated the second reviad after each medical record reviad and after each medical record reviadated 8/1/16 to 8/3 Nurse (LPN) #4, at at 12:23 PM, reveated the second reviadated 8/1/16 to 8/3 Nurse (LPN) #4, at at 12:23 PM, reveated the second reviadated 8/1/16 to 8/3 Nurse (LPN) #4, at at 12:23 PM, reveated the second reviadated 8/1/16 to 8/3 Nurse (LPN) #4, at at 12:23 PM, reveated the second reviadated 8/1/16 to 8/3 Nurse (LPN) #4, at at 12:23 PM, reveated the second reviadated 8/1/16 to 8/3 Nurse (LPN) #4, at at 12:23 PM, reveated the second reviadated 8/1/16 to 8/3 Nurse (LPN) #4, at at 12:23 PM, reveated the second reviadated 8/1/16 to 8/3 Nurse (LPN) #4, at at 12:23 PM, reveated the second reviadated 8/1/16 to 8/3 Nurse (LPN) #4, at at 12:23 PM, reveated the second reviadated 8/1/16 to 8/3 Nurse (LPN) #4, at at 12:23 PM, reveated the second reviadated 8/1/16 to 8/3 Nurse (LPN) #4, at at 12:23 PM, reveated the second reviadated 8/1/16 to 8/3 Nurse (LPN) #4, at at 12:23 PM, reveated the second reviadated 8/1/16 to 8/3 Nurse (LPN) #4, at at 12:23 PM, reveated the second reviadated 8/1/16 to 8/3 Nurse (LPN) #4, at at 12:23 PM, reveated the second reviadated reviadate	ed: plicy Tube Feeding-Hydration,Purpose: To provide proper ding tubeStandard: In tube feedings should include in to be given each ord the cc's [cubic amount of water given at each g with the total amount given ented" plicy Intake and Output uids, undated revealed vide an accurate record of the id outputProcess: Fluids is is calculated and recorded see" ew revealed Resident #1 was and readmitted on 8/16/16 uding Quadriplegia, Bilateral are Vein Thrombosis and tomy, Disease of Esophagus, sity, Anxiety, Depression, sure Ulcer. ew of the Physician Orders 1/16, with Licensed Practical the nursing station on 8/22/16 led the tube feeding formula calorie concentrate at 70 cc for ush Auto per pump at 52 cc rs, and water 30 ml before	F3	322	Corrective Action 1. On 8/22/16 the DON immediately labeled the tub feeding formulary bag with time the formulary was star for resident #1. The tube feeding bag was already labeled with resident's #1 name, date started and the resident to be administered. The amount of formula administered and flushes we documented on the Diet Flow Sheet. The facility reviewed Diet Flow Sheet. The facility reviewed Diet Flow Sheet. The facility reviewed Diet Flow Sheet. All form and there were an negative outcomes from fails to document on 8/16/16, 8/17/16, and 8/19/16. On 8/18/16, 8/20/16, and 8/21/16 there were no negative outcome due to one formulary and one flush bein documented on. On 8/23/16, the DON immediately documented the rate of administration on the label.	the ted ate ere v o o			

STATEMENT AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	TE SURVEY
		445157	B, WING				С
	PROVIDER OR SUPPLIER			20	TREET ADDRESS, GITY, STATE, ZIP CODE 00 STRAHL STREET RANKLIN, TN 37064	1 09	/06/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIET OF THE	D BE	(XS) COMPLETION DATE
F 322	Resident #1 in bed tube feeding formula Further review rev not indicate the tin formula ordered, the administered or the observation reveal the pole. Tube feeding form provide 1540 cc per cc for 22 hours wo The medication fluthe number of medication fluthe number of medication fluthe number of medication fluthe number of the number of the number of the flushes ha "I have provided When asked if the flushes the LPN chand stated " we caw hile now" Whethe LPN stated " interview with LPN nursing station who were administered have auto flush" calculating or acconceded for the flushes form from the revealed no document 8/19/16; and cone formulary and	age 12 If in his room, with 600 ml's of alla in a bag hanging on a pole, ealed the formula bag label did ne of starting the feeding, the ne rate it should be set to be e initials of the nurse, Further ed no water flush bag was on ula at 70 cc for 22 hours would be ready and the water flush at 52 uld provide 1144 cc per day, she would vary depending on dications administered. If 44 on 8/22/16 at 12:22 PM, at 12 station revealed when asked do been provided LPN #4 stated water with medications" LPN had done any other water necked the physician orders don't have auto flush bags for the asked what awhile meant months at least" Further #4 at 12:58 PM at the 1 West the nasked if any water flushes LPN #4 stated "No, we don't When asked how he was unting for what the resident th LPN #4 stated "I have a liew of the 8/2016 Diet Flow he readmission on 8/16/16 hentation on 8/16/16, 8/17/16, one flush was documented. Director of Nursing (DON) on	F:	322	2. On 8/22/16 an audit we conducted by the DON it tube feeding residents to ensure that all formula are labeled with Date, to started, rate of flow, pal name and nurses initial what is being infused. An audit of the diet flow form was conducted for tube feeding residents be unit managers to ensure completetion, findings where the DON on 8/22/16 for licensed nurses regarding proper labeling of tube feeding documenta and water intake on the flow sheet for tube feeding residents. 4 Labels for tube feeding residents will be audited by the Unit Managers to complete labeling. The DE Flow Sheet form will be audited daily x 4 weeks then weekly by the unit managers to ensure compliance, findings will reviewed by the PI/QA meeting monthly	for all to bags ime tients s, and v sheet all by the eting. Interesting tients ing feeding, all tients ing all the biet and between the biet and biet biet biet biet biet biet biet biet	10/20/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445157	B. WING				0
NAME OF PROVIDER OR SUPPLIER CLAIBORNE AND HUGHES HLTH CNTR				ST 20	REET ADDRESS, CITY, STATE, ZIP CODE 0 STRAHL STREET RANKLIN, TN 37064	09/	06/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFIGIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 322	Manager (BOM) off what the DON expethe tube feeding for and administered sithe name of the resistanted and the rate Interview with LPN the 1 West nursing 8/2016 Diet Flow Signature for the 1 West nursing 8/2016 Diet Flow Signature for the 1 West nursing 8/2016 Diet Flow Signature for the 1 West nursing 8/2016 Diet Flow Signature for the 1 West nursing 8/2016 Diet Flow Signature for the 1 West nursing with the label in date, start time, and revealed no rate of documented on the 1 Interview with the Ein the BOM office of the 1 Checked the tube for label did have sommissing the rate"	in the Business Office fice, revealed when asked ected nursing staff to write on mulary bag when it was hung tated "! expect label to have sident, date and time it was to be administered" #5 on 8/22/16 at 5:12 PM, at station, after reviewing the heet form confirmed the facility form completely. 3/16 at 8:15 AM, revealed and the tube feeding formula heluding the resident's name, d initials. Further review administration was label. DON on 8/23/16 at 10:00 AM, confirmed the DON had beeding formulary bag and the te information "but was	F;	3322			
	in the BOM office c	onfirmed the facility falled to et flow sheet for tube feeding					
F 465 SS=E	the BOM office con follow the facility po the fluids every shift 483.70(h)	OON on 8/24/16 at 8:25 AM, in firmed the facility failed to olicy to document the intake of it.	F	465	F465 The facility will provide a safe, functional, sanitary, and comfor environment for residents, staff the public.		

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STATEMENT	OF DEFICIENCIES	(X1) BBOYOFDIGUEDDIATION	T		OMB NO.	0938-0391
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		445157	B. WING		(
NAME OF	PROVIDER OR SUPPLIER		8	TREET ADDRESS, CITY, STATE, ZIP CODE	09/0	06/2016
CLAIBO	RNE AND HUGHES H			00 STRAHL STREET RANKLIN, TN 37064		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	STEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DRE	(X5) COMPLETION DATE
F 465	Sanitary, and comforesidents, staff and This REQUIREMED by: Based on observation failed to maintain 4 total showers and occupied rooms on manner. The findings includ Medical record reviadmitted on 3/4/16 with diagnoses included Lower Extremity Described and Pressent Chronic pain, Obesservation on 8/2 PM, revealed Residube feeding formula bag on a pole with observation revealed the heater/air condition wet to the touch frosill to the floor. Interview with the Eat 9:43 AM, in Residual was wet and wheater/air condition	rovide a safe, functional, ortable environment for I the public. NT is not met as evidenced tion and interview, the facility of 4 first floor showers of 8 I Resident (#1) room of 32 the first floor in a safe ed: ew revealed Resident #1 was abd readmitted on 8/16/16 uding Quadriplegla, Bilateral eep Vein Thrombosis and tomy, Disease of Esophagus, sity, Anxiety, Depression, sure Ulcer. 2/16 at 8:55 AM and 12:18 dent #1 in bed in his room, a la was being administered via h 3 rusted legs. Further ed the wall, to the right side of itioner unit was wrinkled and m the bottom of the window Director of Nursing on 8/22/16 dent #1's room confirmed the rinkled to the right of the er unit.	F 465	Corrective Action 1.a On 8/22/16 resident #1 feeding pole with the rust legs was immediately report by the unit manager On 8/22/16 the wrinkled wet wall to the right side heater/air conditioner in resident #1 room was immediately repaired by maintenance. A roofing votame to inspect the roof leakage The shower room on 1 Eactosest to room 125 was flushed and thoroughly cleaned by housekeeping dead winged insect and the wadded up glove was immediately removed frosecond shower room clos the nursing station on 1 Eactosest to room 125 was immediately removed frosecond shower room clos the nursing station on 1 Eactosest to room 1 West. The urine filled commode flushed and soiled towels removed immediately in the shower room on the left clothe nursing station on 1. On 8/22/16 an audit of the shower rooms were come of the Housekeeping.	sted placed d and e of the n endor for ast . The he est to cast, oor d and in the was he losest least, of all	
ECON CNIO		laintenance Director on		supervisor to ensure t	that the	
EURIYI UMS-20	67(02-99) Previous Versions	Obsolete Event ID: T33N11	Faci	ity ID: environment was safe	and	age 15 of 20

sanitary.

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		445157	B. WING			T	C
	ROVIDER OR SUPPLIER			20	REETADDRESS, CITY, STATE, ZIP CODE 10 STRAHL STREET RANKLIN, TN 37064	1 09/	06/2016
(X4) ID PREFIX TAG	(EAGH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	3 RF	COMPLETION DAYE
	Manager office stal and that's why the value of the fact of the shower room close occupied, had fece brown stain on the The second showe station on 1 East was winged insect on the on the sink. 2.) At 8:50 AM-The The shower room of the sink. 2.) At 8:50 AM-The The shower room of the sink. 3.) At 8:50 AM-The The shower room of the sink. 4.) At 8:50 AM-The The shower room of the sink. 3.) At 8:50 AM-The The shower room of the shower room of the shower room of the shower room of the shower showers and the soiled towels on the showers and the showers and the showers and the facility room of the facility must previous to meet the services to meet the shower showers and the facility must previous to meet the services to meet the shower showers and the facility must previous to meet the services to meet the shower showers and the facility must previous to meet the services to meet the shower showers and the facility must previous to meet the services to meet the shower shower showers and the facility must previous to meet the services to meet the shower shower showers and the facility must previous the facility must previous the services to meet the services t	of, in the Business Office and "there was a roof leak wall is wet". 2/16 during the initial facility office and is shower rooms on 1 East. The st to room 125 was not is in the commode, and a floor in front of the commode. It room closest to the nursing as not occupied, had a dead are floor and a wadded up glove shower rooms on 1 West. On the right was not occupied in on the floor and a brown in seat. The shower room on the nursing station on 1 East, had urine in the commode, and is floor. Director of Nursing, on 8/22/16 M, after observing both 1 East occupied shower on 1 West, ty falled to maintain the afe manner.	F 4			d on on vas vas bris or	10/20/16
	by:	NT is not met as evidenced olicy review, medical record			Findings will be reported to daily QA meeting and revie monthly at the PI/QA meet	wed	

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	O(n) Lui	LITIDA		O		0938-0391
AND PLAN (F CORRECTION	IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DAT	E SURVEY
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	2	445157	B, WING					C
NAME OF	PROVIDER OR SUPPLIER			A 100 PM	FORET LOGGE		09/	06/2016
	4507 598				OO STRAHL ST	S, CITY, STATE, ZIP COUE		
CLAIBOI	RNE AND HUGHES H	LTH CNTR			RANKLIN, TN			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	1 10	<u></u>				VI National
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH C	(IDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD EFERENCED TO THE APPROPE DEFICIENCY)	RE	(X5) COMPLETION DATE
F 502	Continued From pa	ge 16	E	502	F502	ty will provide or obtain		
	review, interview, as	nd pharmacy data review, the	' '	302	laborator	y services to meet the ne	ade	1
	facility failed to follo	w physician orders for			of its resi	dents. The facility is	CHS	
	laboratory tests for	1 Resident (#4) of 9 residents		1	responsil	ble for the quality and		
	reviewed.				timelines	s of the services.		
	The findings include	ad:				C 1003 to their Man House		
	THO INITIALITY INDICAGE	, u.			Correctiv			
	Medical record review	ew revealed Resident #4 was		ļ	1.	On 8/25/15, the DON		
	admitted on 3/17/18	s, and readmitted on 7/28/16		1		immediately obtained at order for the lab work i		
	with diagnoses Inclu	uding Schizophrenia.		1		resident #4.	701	
	Dementia, Anxiety,	Disturbance of Conduct, and		1	2.	On 10/3/16 an audit wa	10	
	Seizure Disorder.					started for all residents	ıa	
	Medical record revie	ew of the Consultant				receiving labs requested	i	
1	Pharmacist Recomi	mendation to Physician form				per pharmacy		
	dated 10/19/15 reve	ealed "resident is currently				recommendation to ens-	ure	i
	taking Divalproex S	prinkles 125 mg 8 capsules at				that current labs were		
	bedtime. The usual	monitored tests are Valproic				being obtained per MD		
	repeat event six me	der ordering baseline labs and				order.		
	revealed the band u	onths" Further review written notation "CMP		1	3.	On 8/25/16 an in-service	ce	
	[Comprehensive Ma	etabolic Panal] + [and]				was conducted by the De	ON	
	Depakote level q [e	very) 6 months"		1		for all licensed nurses regarding processing		
				į		pharmacy		
1	Medical record review	w of the laboratory data		1		recommendations.		
	revealed no laborate	ory results for a CMP and				Procedure: The DON wil	1	
	Depakote level in 10	0/2015.		- 1		receive the pharmacy		
	Interview with the D	ON on 8/25/16 at 12:25 PM.		1		recommendation. The U	nit	
	in the ROM office of	onfirmed the facility failed to		Ī		Managers will notify the		
	write the phone ord	er for the 10/19/15 accepted				MD regarding the		
	pharmacy recomme	endation for lab work and				recommendations. The I		
1	falled to obtain the !	ab work,				will accept or decline the	е	
	1					recommendation of		
	interview with Resid	lent #4's Physician on 8/25/16				pharmacy. If there are n	Q	
		econd floor dayroom				changes nursing will	-1 1	
	recommendation with	g on the 10/19/15 pharmacy as his and his expectation was		1		document no changes no and file. If changes- then		
	for the facility staff to	o write a telephone order and				nursing will transcribe t		
ORM CMS-98	67(02-99) Previous Versions	m				order and process	ue E	l
2 . HT 01110 740	/ ANI LIMBOURS ARIZIOUS	Supplied Event III' [33N44]		Fac	ilih/	process		_

accordingly file in chart

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/12/2016 FORM APPROVED OMB NO. 0938-0391

		& MEDICAID SERVICES			MB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445157	B. WING		C 09/06/2016
NAME OF PROVIDER OR SUPPLIER CLAIBORNE AND HUGHES HLTH CNTR			20	REET ADDRESS, CITY, STATE, ZIP CODE 0 STRAHL STREET RANKLIN, TN 37064	95,05,2515
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 502 F 514 SS=D	"do what was ord 483.75(I)(1) RES RECORDS-COMPLE The facility must man resident in accordate standards and practacurately docume systematically orgate of information to identify the clinical record information to identify resident's assessment services provided; the preadmission screet and progress notes. This REQUIREMENT by: Based on medical and interview, the fracturate and compressidents (#2, 4, and The findings Included Medical record reviadmitted to the factine luding Chronic Medical record reviadmitted to the factine luding Chronic Medical record reviadmitted to the factine luding Chronic Medical record reviadmit record reviadmit record reviadmit record reviational record reviation in the record reviation of the record reviation	ered" LETE/ACCURATE/ACCESSIB aintain clinical records on each note with accepted professional stices that are complete; nted; readily accessible; and nized. must contain sufficient lify the resident; a record of the ents; the plan of care and the results of any ening conducted by the State; solution. NT is not met as evidenced record review, observation, acility failed to maintain plete medical records for 3 and 8) of 9 records reviewed. ed: liew revealed Resident #2 was lity on 6/24/16 with diagnoses (idney Disease Stage 3, sease, Diabetes Mellitus,	F 502	4. Residents with labs requested per pharmacy recommendation will be monitored by the Unit Managers monthly throug crosschecking the original recommendations by the orders received from the MD. Any recommendation unresolved will be submitted to the Medical Director for resolution. Findings will be reviewed monthly at the PI/QA meeting F514 The facility will maintain clinical records on each resident in accordance with accepted professional standards and practithat are complete; accurately documented; readily accessible; a systematically organized. The clinical record must contain sufficient information to identify resident; a record of the resident; assessments; a record of the resident; assessments, the plan of care and services provided; the results of a preadmission screening conducte the State; and progress notes. Corrective Action 1. The facility reviewed shower/bath documentation or resident #2, there were no negative outcomes due to no documentation. Interview with resident #2 shows showers were offers	ices Ind Ithe Is ent's Iny

and declined at times.

CTATEMENT	T OF DECIDIONS	The state of the s	1			MIR NO	. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/S IDENTIFICAT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445157	B. WINC	3		0.0	C
NAME OF PROVIDER OR SUPPLIER CLAIBORNE AND HUGHES HLTH CNTR			STREET ADDRESS, CITY, STATE, ZIP CODE 200 STRAHL STREET FRANKLIN, TN 37064				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	VIEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIES OF THE	DRE	(X5) COMPLETION DATE
F 514	Observation on 8/23/16 PM, and on 8/23/16 Resident #2 was w personal odors were was feeding hersel Interview with Resident facility offered the r stated " Yes" Medical record revior of showers/baths p Interview with the E Licensed Practical beginning at 4:18 F Manager (BOM) of to maintain docume therefore the medic Medical record reviadmitted on 3/17/1 on 7/28/16, with dia Schizophrenia, Der Conduct, and Seizu Medical record reviadmitted on 3/17/1 on 7/28/16, with dia Schizophrenia, Der Conduct, and Seizu Medical record revi Physician Orders for March 2016. Interview with LPN the BOM office con Orders could not be maintain an accura Medical record reviadmitted on the maintain an accura	2/16 at 9:05 AM and 12:28 S at 8:18 AM revealed earing clean clothing, no re noted, was ambulatory, and f her meal at bedside. dent #2 on 8/22/16 at 12:28 's room when asked if the esident showers or baths ew revealed no documentation rovided to Resident #2. Director of Nursing (DON) and Nurse (LPN) #2, on 8/23/16 'M, in the Business Office fice confirmed the facility failed entation of showers provided, cal record was not complete. ew revealed Resident #4 was 5 and readmitted to the facility ignoses including nentia, Anxiety, Disturbance of ure Disorder. ew revealed no signed or January, February and #3 on 8/24/16 at 9:30 AM, in firmed the signed Physician er found and the facility failed to	F	514	The facility reviewed medical record for Resident #4, they were reprinted and signed by the Physician. There were not negative outcomes due to not having signed Physicians orders for January, February and March 2016 The facility reviewed medical record for Resident # 8, there were no negative outcomes due to no documentation of the Activities of Daily Living, Boy movement, food and fluid intake, shower/bath provide from admission on 8/5/16 through 8/18/16. Resident # discharged from facility or 8/18/16. The facility reviewed medical record for Resident # 8, there were no negative outcomes due to no documentation for the 4:30PM fingerstick BS BID result from 8/16/16 to 8/18/16. Resident #8 discharged from facility on 8/18/16. 2. An audit was conducted by the Unit Managers on 8/22/16 to ensure shower/bath documentation was complete for each resident. An audit was conducted by Medical records to ensure Physician Order sheets are signed and in the chart for each resident for January 2016 through present	y t t l e he vel d	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE	(X3) DATE SURVEY COMPLETED	
		445157	B. WING	***************************************			D DOVED 4 D	
NAME OF PROVIDER OR SUPPLIER CLAIBORNE AND HUGHES HLTH CNTR				200	REET ADDRESS, CITY, STATE, ZIP CODE D STRAHL STREET ANKLIN, TN 37064	1 09/0	06/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DRE	(X5) COMPLETION DATE	
F 514	including Depressic Dysfunction of Blac Obsessive-Comput Hearing Loss, Histo Embolism, Benign Insomnia. The resimedical Advice (AMMedical Advice (AMMedical Advice) of the Activities of Education of Education Interview with the Education of the BOM office compave a complete and Medical record revise of blood tests]2.) BID [2 times daily].	on, Neuromuscular Ider, Diabetes Mellitus Type 2, sive Disorder, Conductive Disorder, and Disorder Disorder Disorder, and Disorder D	F		An audit was conducted by unit managers to ensure Activities of Daily Living, Bowel movement, food and fluid intake shower/bath are documented for each resident. An audit was completed by unit manager to ensure finger stick results were documented for all residents that have an order for fingerstick (blood sugar). An in-service for all CNTs and Licensed nurses was conducted by the DON regarding complete documentation of Activities of Daily Living, Bowel movement, food and fluid intake, and shower/ bath. An in-service was conducted for all licensed nurses regarding the maintenance of the signed physicians order sheet in the medical record. An in-service was conducted by the DON for all licensed nurses regarding documentation of finger stick results.			
	the BOM office con have the results of	OON on 8/25/16 at 8:10 AM, in firmed the facility failed to the ordered blood lests in the refore the medical record was			The Unit managers or designee will conduct daily audits of Activities of Daily Living I documentation, Bowel Movement documentation, food and fluid intake and finger stick documentation for 4 weeks and then weekly to ensure compliance. Results will be reviewed in the monthly QA/PI meeting.		10/20/16	